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No. 03-69

IN THE

Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,

Petitioners,

v.

BONNIE CICIO,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF *AMICI CURIAE* THE AMERICAN ASSOCIATION OF HEALTH PLANS, INC., THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN BENEFITS COUNCIL AND THE NEW YORK HEALTH PLAN ASSOCIATION IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The American Association of Health Plans, Inc. ("AAHP"), the Health Insurance Association of America ("HIAA"), the American Benefits Council (the "Council") and the New York Health Plan Association, Inc. ("NYHPA") (collectively "*Amici*") submit this brief in support of the Petitioners, Vytra Health Plans Long Island, Inc. and Brent Spears, M.D.

AAHP is the national association for the managed health care community. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. Its membership includes health maintenance organizations ("HMOs"), preferred provider organizations, third party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 managed health care organizations serving nearly 160 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*

HIAA is based in Washington, D.C., and is one of the largest associations of health insurance companies in the world. HIAA is the nation's most prominent trade association representing the private healthcare system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. It is the nation's premier provider of self-study courses on health insurance and

1. Pursuant to this Court's Rule 37.3(a), letters of consent from all parties to the filing of this brief have been filed with the Clerk of the Court. Pursuant to this Court's Rule 37.6, *Amici* state that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than *Amici*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

managed care. HIAA advocates a private, market-based health insurance system and is dedicated to promoting federal and state health care policies that maximize the quality, affordability, accessibility, and responsiveness of medical services provided to the nation's health care consumers.

The Council is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

NYHPA is the New York State association for the vast majority of health plans offering coverage to residents of New York State. Its membership consists of HMOs, health insurers and prepaid health service plans that serve more than six million New Yorkers, as well as residents of neighboring states, the majority of whom are participants or beneficiaries of employee benefit plans under ERISA. NYHPA has worked closely with public policy officials to develop balanced and innovative approaches that increase health plan accountability for coverage decisions while maintaining affordable health care coverage.

REASONS FOR GRANTING THE PETITION

The foundation of this country's health insurance system is employer-sponsored health care coverage. *See* Employee Benefit Research Institute, *Special Report and Issue Brief, EBRI Research Highlights: Health Benefits* 5 (May 2003) ("Currently, employment-based health insurance is the most common form

of health coverage in the United States."). "Employer-sponsored healthcare reaches nearly two out of every three Americans, including active workers, retirees, and their dependents." The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey* 1 (2002). Employers do not sponsor this coverage because of a government mandate. Rather, employers voluntarily undertake the obligation to administer and pay for their employees' health benefits. The voluntary nature of employer-sponsored health care coverage, and the extent and continued vitality of this system, are a direct result of the policy choices Congress made when it adopted ERISA.

Indeed, Congress enacted ERISA in 1974 in large measure to induce employers to offer and maintain benefit plans for their employees. Congress recognized that uniform federal rules and oversight would encourage the growth of employee benefit plans. To allow employers to provide uniform benefits across all states without having to conform to varying state regulatory environments, Congress included two crucial provisions in ERISA: § 514(a) and § 502(a). 29 U.S.C. §§ 1144(a), 1132(a). The former is a broad preemption statute; the latter a civil enforcement provision that is the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987).

For years following this Court's decision in *Pilot Life*, employers made benefit decisions with the knowledge that ERISA preempted state law claims against benefit plans. Courts held that § 514(a) and/or § 502(a) preempted virtually all state claims, including those against plan administrators for making alleged medically-based eligibility determinations. As a consequence, employers were able to provide health care coverage to their employees without having to comply with fifty sets of state laws. Multi-state employee benefit plans were able

to treat similarly situated employees the same regardless of their state of residence. The environment was one in which incentives existed for employers to provide health benefits to their employees. In fact, by 2001, the percentage of workers covered by employment-sponsored health insurance grew to 73.7%. Employee Benefit Research Institute, *supra* 14.

But the stability and predictability in the law that existed since *Pilot Life* — and served the needs of both employers and employees (including union benefit plans) — is eroding because of decisions such as that of the court below in *Cicio v. Vytra*, 321 F.3d 83 (2d Cir. 2003). The Second Circuit's decision has created a cloud of uncertainty over the countless decisions that plan administrators must make every year and undermines the national uniformity of employee benefits plans. This is true not only for medical necessity decisions — whether an otherwise covered service is medically necessary for a given patient — but also for interpretations concerning explicit contract exclusions of experimental treatments, which, by definition, are not clinically proven and may even be dangerous.

Allowing state claims against plan administrators, even in cases where it is alleged that a decision reflects medical judgment, will now inject the ever-changing law of fifty different states into an area that has been governed exclusively by federal standards. Faced with different state liability rules, employee benefit plans will be forced to treat similarly situated employees differently based on the state in which the participant resides. Additionally, benefit plans will be forced to engage in costly risk management as they weigh the language of the benefits plan and the judgment of plan administrators against the risk of state law claims. Law suits will proliferate and employer costs will increase as benefit plans absorb increased litigation expenses.

Most importantly, a fifty-state patchwork scheme of ERISA enforcement will harm the people who Congress sought to protect — the 131 million Americans who participate in group health plans governed by ERISA, all of which are voluntarily sponsored. *See "Small Business Health Fairness Act": Hearing on HR. 660 Before the Subcom. On Employer-Employee Rel. of the House Comm. On Educ. & the Workforce*, 108th Cong. (Mar. 13, 2003) (statement of Ann. L. Combs, Ass't. Sec'y. for Employee Benefits Sec., U.S. Dep't of Labor) (stating that ERISA protects "approximately 2.5 million private, job-based health plans and 131 million workers, retirees and their families"). The cost of health care coverage will increase while its availability will decrease. Co-payments, co-insurance and deductibles will rise and plan benefits will be reduced or eliminated. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001) ("Requiring ERISA administrators to master the relevant laws of 50 states and to contend with litigation would undermine the congressional goal of 'minimizing the administrative and financial burdens on plan administrators' — burdens ultimately borne by the beneficiaries.").

The disuniformity created by the decision below is compounded by the confusion that now exists in the lower courts regarding the impact of this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000) on state-law claims such as the one at issue here. Like some other courts, the court below mistakenly relied upon the dicta regarding "mixed" treatment and eligibility decisions in *Pegram*. However, *Pegram* was not a preemption ruling and nowhere in that decision did this Court imply it was overruling *Pilot Life* and its progeny, which is controlling in this case.

Accordingly, this Court's review is needed to clarify its decision in *Pegram* and restore Congress' policy of inducing employers to provide voluntarily health care coverage to employees by ensuring the uniform administration of health benefits and the exclusivity of ERISA's remedy scheme.

I. THE DECISION BELOW UNDERMINES CONGRESS' POLICY OF INDUCING EMPLOYERS TO OFFER HEALTH BENEFITS

This Court's immediate review is necessary to settle the law in an area where uniformity and predictability are imperative. Congress intended that ERISA preemption would enable plan administrators to make eligibility determinations without having to refer to fifty sets of state laws. All this has now changed with the recent decisions of the court below and other lower courts. Such decisions undermine Congress' policy choice in ERISA of inducing employers to offer health benefits by ensuring the uniform administration of health benefits and the exclusivity of ERISA's remedy scheme.

After more than a decade of debate, Congress enacted ERISA in 1974 in large measure to encourage employers to offer and maintain benefit plans for their employees. *See* Michael S. Gordon, *Overview: Why Was ERISA Enacted?*, U.S. Senate, Special Comm. On Aging, *The Employee Retirement Income Security Act of 1974: The First Decade*, at 25 (Comm. Print 1984). Although ERISA comprehensively regulates such plans, it leaves in place the voluntary nature of plan sponsorship. *Compare Great-West Life and Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (noting that ERISA is a "'comprehensive and reticulated statute'"), *with* 29 U.S.C. § 1003(a) ("this subchapter shall apply to any employee benefit plan *if it is established or maintained*") (emphasis added). The existence of employee benefits — such as a health care program — is dependent upon employers' willingness to create employee plans.

Congress was mindful that, to the extent government regulation increased benefit plan costs, the result would be to encourage termination of existing plans and discourage

formation of new benefit plans. *See, e.g.*, 120 Cong. Rec. 4295 (1974) (remarks of Rep. Ullman) ("Generally, it would appear that the wider or more comprehensive the coverage, vesting, and funding, the more desirable it is from the standpoint of national policy. However, since these plans are voluntary on the part of the employer and both the institution of new pension plans and increases in benefits depend upon employer willingness to establish or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer."). In order to further the "public interest in encouraging the formation of employee benefit plans," ERISA established uniform regulation and imposed federal oversight in this area. *Pilot Life*, 481 U.S. at 54; *see Egelhoff*, 532 U.S. at 148 ("One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'").

Congress also recognized that plans and their sponsors faced fifty sets of complex and conflicting state laws and regulations. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (stating that Congress' goal in enacting a preemption provision was to minimize "the administrative and financial burden of complying with conflicting directives among State or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction"). Finding that inconsistencies in laws and regulations resulted in administrative inefficiencies and costs that ultimately hurt plan participants, Congress concluded that "employee benefit plans would prosper best if regulated by the federal government without state involvement." William J. Kilberg & Paul D. Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev. 1313, 1313-14 (1984); *see* H.R. Rep. No.

93-533, at 12 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650 ("The uniformity of decision which the act is designed to foster will help administrators, fiduciaries and participants to predict the legality of the proposed actions without the necessity of reference to varying state laws."). That policy judgment has been aptly summarized by this Court:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants . . . [and] making disbursements. . . . The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to . . . process claims in a certain way in some States but not in others. . . .

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987). *See also Egelhoff*, 532 U.S. at 148 ("[u]niformity is impossible . . . if plans are subject to different legal obligations in different states").

Congress sought to achieve the goal of creating a uniform body of benefits law through a broad preemption clause. *See California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316, 324 (1997) (reviewing the Court's many previous acknowledgements that ERISA's preemption provision is "clearly expansive," has a "broad scope," an "expansive sweep," is "broadly worded," deliberately expansive" and "conspicuous for its breadth"). Section 514(a) of ERISA preempts "any and all" state laws that "relate to" an employee benefit plan. 29 U.S.C. § 1144(a).

ERISA's legislative history highlights the intended broad scope of § 514(a) and Congress' concern with the negative effect that litigation would have on employee benefit plans. For example, Senator Jacob Javits, one of ERISA's authors, expressed concern that a narrow preemptive scope would increase the "possibility of endless litigation over the validity of State action that might impinge on Federal regulation," and that "[t]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans . . . required the displacement of State action in the field of private employee benefit programs." 120 Cong. Rec. 29,942 (1974). Congress hoped to avoid "opening the door to multiple and potentially conflicting State laws" by preempting them. *Id.*

Also, in lieu of a multiplicity of state remedies, Congress included a civil enforcement provision in § 502(a) of ERISA. 29 U.S.C. § 1132(a). Sixteen years ago, in *Pilot Life*, this Court held that the provisions of § 502(a) are the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." 481 U.S. at 52. The Court thus established a categorical rule: § 502(a) preempts any state-law claim that purports to provide different or additional judicial remedies for a wrongful denial of benefits. *Id.* at 54. Applying this rule, the Court found that § 502(a) preempted state-law contract and tort claims filed against an insurer for the "bad faith" denial of disability benefits. *Id.* at 55-56.

In the wake of *Pilot Life*, employee benefit plans were able to make health benefit decisions confident that they would not be subject to alternative state law remedies. Time and time again, the circuit courts recognized that ERISA sections 514(a) and/or 502(a) preempt state law claims that challenge an ERISA plan's claims decisions, including claims determinations based on plan provisions that limit coverage to medically necessary treatments or condition coverage on pre-certification. *See, e.g., Hull v.*

Fallon, 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 528 U.S. 1189 (2000); *Danca v. Private Health Care Sys.*, 185 F.3d 1 (1st Cir. 1999); *Jass v. Prudential Health Care Plans, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Cannon v. Group Health Serv. Of Oklahoma*, 77 F.3d 1270 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996); *Tolton v. American Biodyne*, 48 F.3d 937 (6th Cir. 1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). For years, this stability in the law provided plan administrators with the certainty and predictability they needed to plan and administer health benefits budgets.

To be sure, this Court has revisited the scope of ERISA preemption since deciding *Pilot Life*. At no time, however, has the Court departed either from the core principle that § 514(a) preempts state laws and remedies that disrupt the uniform administration of an employee benefit plan or "*Pilot Life's* categorical preemption rule" under § 502(a). *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379-80 (2002). For example, in *New York State Conference of Blue Cross and Blue Shield Plans, Inc. v. Travelers Ins. Co.*, 514 U.S. 645 (1995), the Court narrowed the reach of preemption but, importantly, reaffirmed that "[t]he basic thrust of [ERISA's] preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657. Whatever the outer limits of ERISA preemption might be, the Court reaffirmed that ERISA preempts state laws or causes of action that would undermine the uniform application of benefits. *Id.* at 668 (a state law that would "force an ERISA plan to adopt a certain scheme of substantive coverage" would likely be preempted under ERISA).

Travelers is of a piece with all of this Court's preemption decisions which have consistently emphasized the importance of uniformity and the preeminence of ERISA's enforcement mechanisms. Most recently, in *Rush Prudential HMO, Inc. v. Moran*, this Court again stated that ERISA preempts state laws or causes of action which supplement or add to the remedies

available under ERISA, holding that a law that "provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct." 536 U.S. at 379.

But the goals of predictability and uniformity that Congress sought to implement by broad preemption — and which this Court accomplished in *Pilot Life* — have been severely undermined by the decision of the court below. By permitting state law claims concerning alleged medically-based eligibility determinations, the Second Circuit has authorized the application of substantive state law to the administration of plans providing health care benefits. "[T]he significance of the holding by the Second Circuit cannot be overstated. . . . [I]ts protection of state law causes of action regarding medical practice and health care are monumental." Thomas A. Moore & Matthew Gaier, *Recent Second Circuit Decision on HMO Liability*, N.Y.L.J., Mar. 10, 2003, at 3. If applied everywhere, plan administrators would be required to make eligibility determinations under common law regimes that vary from one state to the next. The impact will be particularly acute on regional or national plans whose beneficiaries reside in different states. These plans will be subject to different and potentially conflicting liability laws, thereby "requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" — exactly the result Congress sought to prevent through the enactment of § 514(a) and § 502(a). *Ingersoll-Rand Co.*, 498 U.S. at 142.

The disuniformity created by the Second Circuit's decision is compounded by the confusion that now exists in the lower courts regarding the impact of this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000) on state-law claims such as the one at issue here. Since *Pegram* was decided, at least seven federal circuit courts and two state courts of last resort have

addressed whether state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA, and have handed-down conflicting decisions based on conflicting rationales. *See Land v. Cigna Healthcare of Florida*, __ F.3d __, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003), *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003); *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002); *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 3, 2003) (No. 02-1826), and *petition for cert. filed sub nom. Aetna Health Inc. v. Davila*, — U.S.L.W. — (U.S. June 20, 2003) (No. 02-1845); *Caffey v. Unum Life Ins. Co.*, 302 F.3d 576 (6th Cir. 2002); *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002); *Pryzbowki v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001); *Villazon v. Prudential Health Care Plan, Inc.*, 843 So.2d 842 (Fla. 2003); *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys.of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002).

Thus, plan administrators must now divine not only the applicable federal law, but also the underlying state law in those jurisdictions that, like the Second Circuit, have subjected benefit decisions to state law causes of action. The difficulty of this task cannot be underestimated. Consider, for example, Pennsylvania, where the Third Circuit is at loggerheads with the Pennsylvania Supreme Court. In 2001, the Third Circuit held that ERISA preempts a state law claim for negligent delay in providing treatment, concluding that *Pegram* did not change the preemption analysis. *Pryzbowski*, 245 F.3d at 273. That same year, by contrast, the Pennsylvania Supreme Court invoked *Pegram* in holding that ERISA did not preempt a state law claim for medical malpractice where the benefit plan administrator makes a "mixed eligibility and treatment decision." *Pappas v. Asbel*, 768 A.2d at 1095-96. This situation has now become untenable for plan administrators in Pennsylvania. *See* Shannon P. Duffy & Randall J. Peach, *Split Decisions*, The Legal Intelligencer, April 6, 2001, at 1 ("What's a Pennsylvania lawyer

to do now that two of the highest courts in the land . . . have issued conflicting back-to-back opinions on the issue of when [a plan administrator] can be hit with a medical malpractice suit?").

Similarly, the court below was divided over the meaning of the dicta in *Pegram* that "mixed eligibility and treatment decisions" made by HMOs acting through their physician employees are not fiduciary acts within the meaning of ERISA. *Pegram*, 530 U.S. at 229. Seizing on that language, the majority held that if a state law malpractice action against an HMO is based on a "mixed eligibility and treatment decision," it is not subject to ERISA preemption so long as the state law cause of action involves allegations of faulty medical judgment. *Cicio*, 321 F.3d at 102. This was a significant misreading of *Pegram*, which was not a preemption ruling, as this Court itself recognized. 530 U.S. at 236-37. As Judge Calabresi's dissent points out:

> [*Pegram's*] well intentioned dicta can only make sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed a treating physician or such a physician's employer, as was the case in *Pegram*. Where, as here, no such relationship existed, there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage that is not based on medical error.

Cicio, 321 F.3d at 109 (Calabresi J., dissenting).

In sum, an employee benefit plan can no longer maintain a nationally uniform administration of employee benefit plans because in many states the plan administrators must now reference state law rules. This Court's immediate review is necessary to restore the stability and consistency in the law that Congress found necessary to encourage employers to offer health benefits to their employees.

II. THE DECISION BELOW RAISES IMMEDIATE PRACTICAL PROBLEMS FOR ADMINISTRATORS OF EMPLOYEE BENEFIT PLANS THAT WILL ULTIMATELY HARM PLAN PARTICIPANTS

The decision below creates real and immediate operational issues for multistate employee benefit plans that will ultimately harm plan participants. Requiring plan providers to design their programs in an environment of differing state standards will complicate the administration of plans and increase the cost of health care coverage. In response, many employers will have no alternative but to reduce coverage to plan participants. Likewise, permitting state law claims will result in increased lawsuits arising out of benefit determinations that will drive-up the cost of administering and providing health care coverage and further undermine employers' willingness to provide coverage voluntarily. As one commentator has noted:

> Removal of ERISA preemption and adoption of more state liability laws could lead to an environment where HMOs and managed care plans are defending a number of lawsuits against a number of different plaintiffs in a number of different states arising under a number of different types of causes of action. This is exactly the environment from which Congress was trying to protect employee benefit plans generally when it enacted ERISA in 1974.

See Matthew J. Binette, *Comment: Patients' Bill of Rights: Legislative Cure-All or Prescription for Disaster?*, 81 N.C.L. Rev. 653, 693-94 (2003).

Such practical problems are illustrated by the very type of procedure at issue in this case. Vytra denied coverage of the double cell stem transplant on the grounds that it was an experimental treatment and, as such, was excluded from coverage under the express terms of the insurance contract.

Cicio, 321 F.3d at 88. In essence, the employee benefit plan had determined that there was insufficient clinical research or experience demonstrating that the treatment was efficacious or even safe for patients. Prior to the decision below, Vytra's determination would have been the same regardless of the jurisdiction in which a plan beneficiary resided; it would not cover this type of procedure. Now, Vytra must consider a range of factors. It first must determine what the law is in the jurisdiction in which the employee resides. If the employee resides outside the Second Circuit — for example in New Jersey — Vytra then may be able to administer the plan as contracted. If the employee resides in New York, however, Vytra must consider the applicability of the underlying state law and the degree to which state law claims might exist.

The situation is further complicated by the difficulty of assessing the applicability of state law to experimental treatments or other new medical technology developments. In effect, a plan administrator must speculate as to how state law judges and juries will evaluate experimental treatments and new medical technology for which there will exist no precedent. No reliable standards exist for a plan administrator to gauge how state law will apply to such determinations.

This is especially problematic because medical professionals often make claims regarding the efficacy of unproven, risky therapies only to see such claims eventually disproven by clinical trials. Instructive, on this point, is *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998), *cert denied*, 528 U.S. 870 (1999), which involved a state law claim against a plan administrator that denied as experimental autologous bone marrow transplant ("ABMT") procedures to treat a woman's breast cancer. The Ninth Circuit concluded that the state law claim was preempted by ERISA, notwithstanding that an oncologist had recommended ABMT procedures. *Id.* at 1005, 1007-08. Notably, clinical trials subsequently

demonstrated that ABMT does not confer any greater chance of survival than conventional therapy. Patricia C. Kuszler, *Financing Clinical Research and Experimental Therapies: Payment Due, But From Whom?*, 3 DePaul J. Health Care L. 441, 457-462 (2000) (recounting history of ABMT). By that time, as many as 30,000 women had received the treatment, at considerable risk to their health — in fact, the treatment carried a death rate as high as 7.4%. *Id.* at 460-61.

Further, requiring benefit plan administrators to apply varying statutes and common law definitions of "experimental treatments" — to the extent such definitions exist — will limit the flexibility now enjoyed by benefit plan administrators to tailor plans to meet employers' and employees' needs and budgets. It also may result in one state being able to dictate plan designs on a nationwide basis.

In any event, the decision below and the more general confusion of the law in this area forces plan administrators to treat similarly situated employees differently. Although most employee benefit plans seek to provide the same coverage to all similarly situated employees, plan administrators must now consider whether to allow some employees to receive certain treatments out of fear of litigation even though a similar employee in a different state is not allowed the very same treatment.

For example, the employee benefit plan at issue in this case had an exclusion for experimental treatments. Prior to the Second Circuit's decision, an employee benefit plan in the downstate New York region could apply that exclusion uniformly regardless of whether its employees lived in New York, New Jersey or Connecticut. Under the Second Circuit's decision, however, an employer will have to abide by a new set of rules, which are based on different state common law causes of action and different state standards as to what is appropriate medical care. Employers must therefore do precisely

what Congress sought to prevent: predict the legality of a proposed action by referring to varying state laws.

Employers subject to the Second Circuit's jurisdiction will likely respond in two ways — both harmful to employees. Some employers may discontinue health care coverage rather than face the uncertain rules, litigation and higher costs that now apply to coverage determinations. Other employers may increase employee contributions or restrict benefits to counter-balance the higher risks employers now face. *See* Milt Freudeinheim, *Employees Paying Ever-Bigger Share for Health Care*, N.Y. Times, September 10, 2003, at A1 (reporting on authoritative study showing that almost 2/3 of large employers with employer-sponsored health plans raised the amounts that employees are contributing to the cost of their health plans this year, and 79% say they will do so again in 2004); The Business Council of the State of New York, Compensation Data New York 2003 (2003) (survey of New York employers reflects that, in a 12-month period ending in April 2003, more than 1/3 of employers increased the employee portion of health insurance premiums, and nearly 1/3 increased deductible levels). In either case, the decision below will undermine Congress' goal of encouraging employer-sponsored health coverage.

Every day plan administrators must make benefits decisions. These decisions are now being made under a cloud of uncertainty and risk of second guessing by state judges and juries. The situation is unworkable for plan administrators and their inevitable reaction may well have profound and unintended consequences for beneficiaries. Accordingly, *Amici* respectfully request that the Court grant the petition for certiorari to reestablish clear guidance not only for lower courts, but also for the plan administrators now confronted with the uncertainty and disuniformity Congress sought to avoid.

CONCLUSION

The petition for certiorari should be granted.

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